

# 2009 Camper Health Form

Child's Last Name	First	Middle	Sex	Date of Birth
Address		City	State	Zip
Home Telephone				
With whom does the camper reside? (Circle One) Both Mother Father Other _____				
If Parents are separated, please list both set of names and addresses.				
Custodial Parent or Legal Guardian Name		Address	City	ST
				Zip Code
				Work Phone
Non-Custodial Parent Name		Address	City	ST
				Zip Code
				Phone

Does your child suffer from any of the conditions listed below	Yes	No		Yes	No
1. Allergies (to food/medicine/ hay-fever), asthma, wheezing			7. Trouble with passing urine or bowel movements		
2. Eczema or frequent skin rashes			8. Shortness of breath		
3. Convulsions/Seizures			9. Speech problems		
4. Heart Trouble			10. Menstrual problems		
5. Diabetes			11. Dental Problems		
6. Frequent colds, sore throats, ear aches (4 or more per year)			12. Other (current contagious diseases etc.)		

Please explain any "Yes" answers identified above:

Have girls been told about menstruation (answer if appropriate) Yes No | Has girl menstruated (answer if appropriate) Yes No

Special Physical, Emotional, or Behavioral considerations which would inhibit activities such as swimming, running, or other physical activities:

Conditions to be watched for such as bedwetting, fainting, sleepwalking, etc. Also, please list any dietary needs that your child has:

Immunizations		Polio	Mumps	Diphtheria	Tetanus	Pertussis (whooping Cough)	Measles	Rubella	Other	
	Date Initial Immunization Completed									
	Date of most recent booster									

Medications	<b>Note:</b> All medications, prescription and over-the-counter, must be kept by the Health Officer in the original container from pharmacy with dosage and frequency clearly marked						Currently being given	
	Kind	Frequency	Dosage	Yes	No			

Name of Personal Physician: \_\_\_\_\_

Address: \_\_\_\_\_  
Street Address City State Zip Phone

In accordance with Federal Law and US Department of Agriculture policy, this institution is prohibited from discriminating on the basis of race, color, national origin, sex, age, religion, political beliefs, or disability. (Not all prohibited bases apply to all programs). To file a complaint of discrimination write to USDA, Director, Office of Civil Rights, 1400 Independence Avenue, S.W., Washington, D.C. 20250-9410 or call (800) 795-3272 or (202) 720-6382(TTD). USDA is an equal opportunity provider and employer."

**(OVER)**

**Insurance/Medicaid Information**

Policyholder's name: \_\_\_\_\_ Relationship to camper \_\_\_\_\_

Policyholder's Address: \_\_\_\_\_  
Address City State Zip Phone

Name and address of insurance company: \_\_\_\_\_  
\_\_\_\_\_

All policy numbers (please identify): \_\_\_\_\_  
\_\_\_\_\_

**Please Attach a Copy of Your Insurance/Medicaid Card**

**Emergency Contact Information**

Please list someone to be contacted in case of emergency if parent or legal guardian **CANNOT** be reached.

Emergency Contact: \_\_\_\_\_

Relationship to camper: \_\_\_\_\_ Phone Number: \_\_\_\_\_

Address: \_\_\_\_\_  
Address City State Zip

**4-H Camp Kidwell Health Statement**

Please **INITIAL** below to indicate that you have read, understood and agree to the section following your initials.

*Parents/guardians/legal representatives should initial on behalf of participating minors, under 18 years of age, after discussing each section with them, indicating that both the minor and parent/guardian/legal representative agree to each section.*

\_\_\_\_\_ **I give permission for my child to attend 4-H Camp Kidwell and participate in activities such as, but not limited to, swimming, horseback riding, running, climbing, hiking etc and camping-based activities that, by nature are physically and emotionally demanding.**

\_\_\_\_\_ **I understand that participating in the camp activities may involve risk, both known and unknown.**

\_\_\_\_\_ **I acknowledge that my child is in good health, and I assume the health responsibility for my child during their time at 4-H Camp Kidwell with the understanding that I will be notified immediately if anything unforeseen occurs.**

\_\_\_\_\_ **I give my consent to 4-H Camp Kidwell, a children's camp licensed by the Department of Human Services in Michigan, and to emergency medical personnel to treat my child while at camp if they deem it to be medically necessary. I understand every effort will be made to contact the person(s) designated to be notified in case of emergency, but if 4-H Camp Kidwell employees do not have time to do so, I authorize 4-H Camp Kidwell staff to secure such medical advice and services as they feel necessary for my child's health or well-being. I give permission for emergency anesthesia and/or surgery that might be necessary due to an illness or injury occurring during my child's participation. (If there is a religious objection to consenting to receipt of emergency medical or surgical treatment, I (or authorized person) should submit a written statement to the effect that I am in good health and that the person signing assumes the health responsibilities for the camper)**

\_\_\_\_\_ **I agree to accept financial responsibility for any medical expenses and/or loss of income not covered by my insurance policy that occurs as a result of my child's participation in the camping program.**

\_\_\_\_\_ **I will not hold 4-H Camp Kidwell, Allegan County 4-H Clubs, and their respective agents, officers, board members, representatives, employees, and volunteers responsible for injuries occurring to my child while at camp due to his or her participation in activities relating to the operation of the camping program.**

\_\_\_\_\_ **I understand that my child may be sharing lodging with an unrelated adult (21 or older) who has been through MSU Extension Volunteer Selection Process and with at least one other young person. I accept these lodging conditions.**

By signing below I am agreeing that I have carefully read and agree to all of the sections initialed above. I am also verifying that the information provided on the health form is accurate to the best of my knowledge. (Please complete the health form prior to signing this document.)

\_\_\_\_\_  
Parent/legal guardian printed name

\_\_\_\_\_  
Parent/legal guardian signature

\_\_\_\_\_  
Date

The content of this health form will only be viewed by appropriate members of the Camp Kidwell Staff.